

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2597

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **277**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY 2139	
b. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS	
c. LENGTH OF STAY (In this place) 2 YRS.		d. STREET ADDRESS (If rural, give location) 13 ST LOUIS STATE HOSPITAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST LOUIS STATE HOSPITAL			

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) MORRIS	b. (Middle)	c. (Last) HIRSCHWITZ	(Month) (Day) (Year) Jan. 10, 1950

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH Unknown about 57	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAPER HANGER	11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME WALDE HIRKOWITZ	13b. MOTHER'S MAIDEN NAME ROSE HIRKOWITZ	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Bessie Rosen 13899 Shawmut pl.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. x
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Generalized Arteriosclerosis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 1, 1947**, to **Jan. 10, 1950**, that I last saw the deceased alive on **Jan. 10, 1950**, and that death occurred at **9:55 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE George A. Mahler, M.D.	(Degree or title)	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 1/10/50
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE BURIAL 1-11-1950	24c. NAME OF CEMETERY OR CREMATORY BETH HAMMOBROSH HAGODA	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO
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DATE REC'D BY LOCAL JAN 11 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Oxenhandler	ADDRESS 5010 Enright Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. J. Oxenhandler

Licensed Embalmer No. 3669

P. O. Address 5010 Enright Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.